KRAEMER
WOMEN'S CARE

Patient Name: _____ Sex: _____ M _____ F
Race: _____ Ethnicity: _____ Preferred Language: _____
Social Security#: _____ Date of Birth: _____
Address: _____ Apt: _____
City, State: _____ Zip Code: _____
Home Telephone (Primary): _____ Work: _____ Cell: _____
Email Address: _____
Employer: _____ Occupation: _____
Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed _____ Separated
Spouse's Name: _____
Spouse's Employer _____ Employer Phone #: _____
If patient is a minor,
Guardian Name: _____ Relationship: _____
Date of Birth: _____ Social Security #: _____
Address: _____ Contact #: _____
_____ Email: _____

Emergency Contact: (person not living in your household)
Name: _____ Relationship: _____
Address: _____ Apt: _____
City, State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ Work: _____

Insurance
Primary Insurance Co. Name: _____
Member, Policy, or ID Number: _____ Group#: _____
Claims Address: _____ City, State: _____
Policy Holder's Name: _____ Date of Birth: _____
Address and Phone: _____
Secondary Insurance Co. Name: _____
Member, Policy, or ID Number: _____ Group #: _____
Claims Address: _____ City, State: _____
Policy Holder's Name: _____ Date of Birth: _____
Address and Phone: _____

RELEASE (Please Read Carefully)

I authorize the release of any medical information necessary to process this claim and any other future claims. I also authorize payment of medical benefits Kraemer Women's Care, LLC. In the event that my insurance company does not cover services, I will be responsible for any unpaid balances, subject to any interest or late fees, or collection fees of 33% and/or litigation fees. KWC, LLC also reserves the right to access your prescription monitoring program report.

Signature: _____ Date: _____
Relationship to Patient: _____

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Patient Telephone Consent:

_____

(Please Print) (Last Name, First Name)

Do we have permission to:

Send a recall appointment to your home: Yes No

Leave the following on your

	Home Voicemail:		Work Voicemail:	
Appointment Information:	Yes	No	Yes	No
Billing Information:	Yes	No	Yes	No
Medical Information:	Yes	No	Yes	No

I give permission to share appointment, medical and billing information with the person names below:

Name:_____ Relationship:_____

_____ _____

(signature) (date)

460 CLEMSON ROAD | COLUMBIA, SC 29229 | P 803 438.3800 | F 803 438.3898
3 MEDICAL PARK DRIVE, STE. 270 | COLUMBIA, SC 29203 | P 803 753.7524 | F 803 753.8389
3020 SUNSET BOULEVARD, STE. 105 | WEST COLUMBIA, SC 29169 | P 803 798.7660 | F 803 216.0388

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Administrative Charges

As many of you may already know, practicing medicine has become increasingly expensive. In order to defray some of the costs that are not covered by our patinent's insurance plans, we have been charging for some administrative services that we provide to patients. We want to inform you of these charges in advance:

1. We charge $25.00 to copy your medical records and mail it out for you.

2. To fill out forms related to your insurance or disability claim, or to write a letter on your behalf, we charge $15.oo (charge is per form) Letters are $20.00

Lab Fees

Most of our lab samples are sent to Labcorp (Laboratory Corporation of America) and/or PPS (Professional Pathology Services). Please inform the medical Assistant if your insurance covers either of those labs or if you are required by your insurance to use a different lab. It is the patient's responsibility to pay for any lab work not covered by their insurance. In the past such test as the Cystic Fibrosis Carrier screen for pregnant patients has been denied by Private Insurance carriers such as Blue Cross Blue Shield. The cost of some of the testing can exceed $800 per test. Please keep in mind all insurance plans differ, there may be other cost associated with your plan that you will be responsible for.

Please be sure to inform the receptionist of any insurance changes.

_____ Printed Name

_____ _____

(signature) (date)